Department of Management & Budget
Office of Retirement Services
www.michigan.gov/ors (800) 381-5111
P.O. Box 30171
Lansing MI 48909-7671

Insurance Enrollment/Change Request

For Judges Retirees

MEMBER'S NAME (LAST, FIRST, M.I.)	MEMBER ID OR SSN
MAILING ADDRESS	DAYTIME TELEPHONE ( )
CITY, STATE, ZIP CODE	

Use this form to enroll in one or more of the retirement system insurance plans, change from one health plan to another, or add, delete, or change a name for anyone on your existing insurance coverage. Also use this form to notify the Office of Retirement Services (ORS) if you or any of your covered dependents become eligible for Medicare or other health, dental, vision or prescription group insurance coverage.

Section I: Current Insurance Coverage

Insurance Plans and Coverage Available

If you wish to *enroll* in plan coverage or *change* your insurance plan enrollment, you can select from either the BCBSM / PPO or an HMO for your health coverage. Check the "enroll" box for the plan you are selecting and indicate who you wish to have covered under that plan. If you wish to *cancel* insurance coverage, see *Canceling Insurance Coverage* below.

Whether you are enrolling in or changing coverage, there is a 6-month waiting period unless you have a qualifying event. (See the instructions.)

☐ ENROLL IN **BCBSM/PPO**	—	☐ SELF	☐ SELF & SPOUSE	☐ SELF & CHILD(REN)	☐ FULL FAMILY
☐ ENROLL IN **DENTAL**	—	☐ SELF	☐ SELF & SPOUSE	☐ SELF & CHILD(REN)	☐ FULL FAMILY
☐ ENROLL IN **VISION**	—	☐ SELF	☐ SELF & SPOUSE	☐ SELF & CHILD(REN)	☐ FULL FAMILY

Canceling Insurance Coverage

If you wish to *cancel* insurance coverage, complete the information below for those individuals you are removing. If you are making no other changes to your coverage, go to Section IV, sign the form and return it to ORS.

NAME (LAST, FIRST, MIDDLE)	MEDICARE #/SOCIAL SECURITY #
QUALIFYING EVENT: ☐ DEATH ☐ DIVORCE ☐ OTHER: _____	DATE OF EVENT:
TYPE OF COVERAGE BEING CANCELED: ☐ HEALTH ☐ DENTAL ☐ VISION	RELATIONSHIP

NAME (LAST, FIRST, MIDDLE)	MEDICARE #/SOCIAL SECURITY #
QUALIFYING EVENT: ☐ DEATH ☐ DIVORCE ☐ OTHER: _____	DATE OF EVENT:
TYPE OF COVERAGE BEING CANCELED: ☐ HEALTH ☐ DENTAL ☐ VISION	RELATIONSHIP

R452B (Rev. 8 / 2007)
Authority: 1992 PA234, as amended

Section II: Self and Dependent Coverage Data

Complete the following information about yourself and all newly-enrolled dependents. You will need to provide proofs for dependents. See the instructions for details on eligible dependents and required proofs.

If any of your currently enrolled dependents are now covered under another insurance plan, including Medicare, you must indicate that additional coverage below. Include the Medicare effective date from the card, if applicable.

NAME (LAST, FIRST, MIDDLE)	MEDICARE #/SOCIAL SECURITY #	DATE OF BIRTH	SEX ☐ M ☐ F
QUALIFYING EVENT: ☐ ADOPTION ☐ BIRTH ☐ MARRIAGE ☐ OTHER	DATE OF EVENT:	RELATIONSHIP: SELF	
NAME OF OTHER INSURANCE COVERAGE (INCLUDING MEDICARE)	POLICY #	MEDICARE, EFFECTIVE DATES PART A PART B	
POLICY HOLDER'S NAME:	TYPE OF COVERAGE: ☐ HEALTH ☐ DENTAL ☐ DRUG ☐ VISION		

DEPENDENT'S NAME (LAST, FIRST, MIDDLE)	MEDICARE #/SOCIAL SECURITY #	DATE OF BIRTH	SEX ☐ M ☐ F
QUALIFYING EVENT: ☐ ADOPTION ☐ BIRTH ☐ MARRIAGE ☐ OTHER	DATE OF EVENT:	RELATIONSHIP:	
NAME OF OTHER INSURANCE COVERAGE (INCLUDING MEDICARE)	POLICY #	MEDICARE, EFFECTIVE DATES PART A PART B	
POLICY HOLDER'S NAME:	TYPE OF COVERAGE: ☐ HEALTH ☐ DENTAL ☐ DRUG ☐ VISION		

DEPENDENT'S NAME (LAST, FIRST, MIDDLE)	MEDICARE #/SOCIAL SECURITY #	DATE OF BIRTH	SEX ☐ M ☐ F
QUALIFYING EVENT: ☐ ADOPTION ☐ BIRTH ☐ MARRIAGE ☐ OTHER	DATE OF EVENT:	RELATIONSHIP:	
NAME OF OTHER INSURANCE COVERAGE (INCLUDING MEDICARE)	POLICY #	MEDICARE, EFFECTIVE DATES PART A PART B	
POLICY HOLDER'S NAME:	TYPE OF COVERAGE: ☐ HEALTH ☐ DENTAL ☐ DRUG ☐ VISION		

DEPENDENT'S NAME (LAST, FIRST, MIDDLE)	MEDICARE #/SOCIAL SECURITY #	DATE OF BIRTH	SEX ☐ M ☐ F
QUALIFYING EVENT: ☐ ADOPTION ☐ BIRTH ☐ MARRIAGE ☐ OTHER	DATE OF EVENT:	RELATIONSHIP:	
NAME OF OTHER INSURANCE COVERAGE (INCLUDING MEDICARE)	POLICY #	MEDICARE, EFFECTIVE DATES PART A PART B	
POLICY HOLDER'S NAME:	TYPE OF COVERAGE: ☐ HEALTH ☐ DENTAL ☐ DRUG ☐ VISION		

Section III: Name Change

If you have a name change, indicate that change below. Please provide legal documentation of your name change such as a copy of a marriage certificate or social security card. Then sign in Section IV.

FORMER NAME (LAST, FIRST, MIDDLE)	NEW NAME (LAST, FIRST, MIDDLE)

Section IV: Certification

I certify that the above information is correct to the best of my information, knowledge, and belief. By my signature below I also agree to the conditions of enrollment specified in this form's instructions.

PENSION RECIPIENT/CONTRACT HOLDER SIGNATURE	DATE

Insurance Enrollment/Change Request Instructions

For Judges Retirees

Department of Management and Budget

Enrolling In or Changing Insurance

Use this form to enroll in or change your insurance plans. Your cost for insurance premiums, shown on the enclosed insurance rate sheet, is deducted from your monthly pension payment.

You may also enroll in the state's dental and / or vision plan. The total premium for dental and vision coverage can be deducted from your monthly pension payment.

Enrolling After Retirement. Pension recipients who did not enroll in one or more of the retirement system insurance plans as part of the initial application must use this form to enroll. Currently enrolled pension recipients who are changing from one health care plan to another must also complete this form.

Regardless of the insurance plan(s) you select, your coverage will begin on the first day of the sixth month after ORS receives all required forms and proofs. For example, if we receive your *Insurance Enrollment/ Change Request* form with the necessary proofs of eligibility on February 10, your coverage would begin August 1.

We can waive the waiting period if you or a dependent has an involuntary loss of other group coverage or a change in your family status. If we receive your *Insurance Enrollment/Change Request* form, along with proof of your loss of coverage, within 30 days of the event, there will be no gap in your coverage.

Self and Dependent Coverage Data

Complete all requested information for each person who will be covered under your insurance plans. If anyone is enrolled in Medicare, provide that person's Medicare card number and the effective dates of coverage for both Medicare Part A and Part B. Please send ORS a copy of the Medicare card for anyone who is under age 65.

Eligible Dependents

Coverage for your eligible dependents is the same as yours. Eligible dependents for health, dental, and vision plans include:

Your spouse as long as he or she is not also separately enrolled as an eligible state employee or retiree.

Your unmarried children by birth, legal adoption, or legal guardianship who are in your custody and dependent on you for support. Coverage ceases the end of the month in which they turn 19. However, if your coverage is still active, your dependent child can remain eligible through the month in which the child turns 25 if he or she is:

Unmarried and between the ages of 19 and 25.
Dependent on you for financial support.
A student who regularly attends school.

If your enrolled dependent is an incapacitated child, coverage will continue as long as he or she became incapacitated before age 19, continues to be incapacitated, and your coverage does not terminate for any other reason. Incapacitated children are those who are unable to earn a living because of a mental or physical impairment and must depend on their parents for support and maintenance.

Qualifying Events

The following are considered qualifying events for the purpose of adding / deleting a dependent. You must submit the indicated proof with this application.

Adoption. Acceptable proof is adoption papers. In the case of legal adoption, a child is eligible for coverage as of the date of placement. Placement occurs when you become legally obligated for the total or partial support of the child in anticipation of adoption. A sworn statement with the date of placement or a court order verifying placement is required.

Birth. Acceptable proof is a birth certificate.

Death. Acceptable proof is an original death certificate.

Divorce. Acceptable proof is divorce papers.

Marriage. Acceptable proof is a marriage certificate.

Loss of coverage in another group plan. Acceptable proof is a statement from the terminating group insurance plan (on letterhead) explaining who was covered, why coverage is ending, and the date it ends.

Adjustments to Premiums

If you are changing insurance coverage, ORS will adjust your premiums, if needed, the month after we receive this form and all required proofs. We cannot refund premiums withheld before or in the month you report the change. If you are adding a spouse or dependent, there is a 6-month waiting period unless you have a qualifying event. The 6-month waiting period may be waived if you submit this form and required proofs within 30 days of the qualifying event.

www.michigan.gov/ORSJudgesDB

P.O. Box 30171
Lansing, MI 48909-7671

(517) 322-5103 (Local)
(800) 381-5111

R452B (Rev. 8/2007) Authority: 1992 PA 234, as amended

Required Proofs for Dependent Coverage

You must provide birth certificates as proof of age and relationship, tax returns as proof of dependency, school records as proof of full-time attendance, and court orders to prove legal guardianship.

To ensure coverage for your incapacitated child, before the end of the month in which the child turns 19, you will need to provide a letter from a physician stating the child is incapable of self-sustaining employment, along with a copy of the IRS form *1040* that identifies the child as your dependent. In addition, every year you may be asked to furnish proof of incapacitation and dependency.

Reporting Other Insurance Coverage Including Medicare

If you or your dependents enroll in other health insurance plans, it is your responsibility to notify ORS of any changes in your status or that of your family that may affect eligibility and / or coverage. If anyone on your plan(s) currently has Medicare, you must complete the Medicare information on the front of this form.

As soon as you or any of your covered dependents become eligible for Medicare, you must enroll in both Part A and Part B. If that happens before the age of 65, send ORS a copy of the Medicare Card. (For most people, Medicare begins at age 65 or after 24 months of social security disability eligibility.)

Your health plan coordinates with Medicare. If you don't enroll in Medicare Part B, you will be personally responsible for any medical expenses that would be covered by Medicare. Your retirement system health plan will continue to pay for any of the plan's covered benefits that are not covered by Medicare.

Medicare D is a prescription drug program introduced by the federal government in 2006. Blue Cross / Blue Shield will automatically enroll you in Medicare Part D. Be sure your carrier knows your Medicare number.

Coordination of Benefits. Your health, dental, and vision plans contain a *coordination of benefits (COB)* provision, which says you can't be reimbursed for more than the allowed cost of your care or service. If you or your dependents are covered under another group plan, the plans coordinate their reimbursement so that their combined payments don't exceed the allowed costs.

Conditions of Enrollment

My signature on this *Insurance Enrollment/Change Request* form indicates I agree to the conditions held herein. I understand that when ORS accepts this form, my family members and I are bound by all conditions stated in the plan. I agree it is my responsibility to notify ORS of any changes in my status and that of my family that may affect eligibility or coverage. I agree that should claims be paid on an ineligible individual, the cost of such claims may be deducted from future pension checks.

I authorize the administrator selected by ORS to obtain from providers of service any and all records and other information relating to me and my covered family members. I understand such information may be made available to ORS, on a confidential basis, for the purpose of evaluating the operation and efficiency of the plans and providers. The duration of this authorization extends for the period of my coverage under the plan.

Group Insurance Contact Information

State Health Plan – Blue Cross Blue Shield of Michigan
P.O. Box 80380, Lansing, MI 48908-0380
(800) 843-4876 or (517) 322-9515 Group #81828

Prescription coverage - Express Scripts' Participating Pharmacy ID Card Plan Prescription Co-Pay Card & Mail Order Pharmacy. Visit Express Scripts' website: www.express-scripts.com or call them at (800) 505-2324.

State Dental Plan – Delta Dental Plan of Michigan
P.O. Box 9085, Farmington Hills, MI 48333-9085
(800) 524-0150 Group #8600

Options Mental Health
(for retirees enrolled in the State Health Plan)
P.O. Box 12698, Norfolk, VA 23541-0698
(800) 277-1122

State Vision Plan – Blue Cross Blue Shield of Michigan
P.O. Box 80380, Lansing, MI 48908-0380
(800) 843-4876 or (517) 322-9515 Group #81828